FLEXIBLE SPEND	FLEXIBLE SPENDING ACCOUNT • REIMBURSEMEN	EMENT REQUEST FORM	PLAN YEAR
PLEASE READ T PLEASE S	PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS FORM PRIOR PLEASE STAPLE SUPPORTING DOCUMENTATION TO THE BACK OF	RM PRIOR TO COMPLETION. BACK OF THIS FORM	
NAME	HOME PHONE (DAY PHONE (
ADDRESS	CITY	STATE ZIP	
SOCIAL SECURITY NO	EMPLOYER		

A. NAME_

	TOTAL					nedical supply store, etc. you paid for it.	* "Provider" means hospital, doctor, dentist, drugstore, medical supply store, etc. ** Use date on which service was provided, not the date you paid for it.
be reimbursed	Mo/Day/Yr	Mo/Day/Yr	or Co-Pay			to employee	receiving services
Amount to	: ⁾	From	Deductible	Provider of services*	Provide	Relationship	Name of person
	*	Dates of service **	_			-	SUMMARY OF EXPENSES
		-				our medical coverag	Is any portion of the service covered by your medical coverage?
Yes□ No□	ductible: /ment?	Was the amount applied to your deductib Was the amount vou paid a co-pavment?	Was the amount applied to your deductible Was the amount you paid a co-payment?	 	Yes □	ises? ish an HMO plan?	Do you have coverage for medical expenses? Is your medical coverage provided through an HMO plan?

C. DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT	LEXIBLE SI	PENDING ACCOU				
Is the facility Tax Exempt?***		Yes 🗆 No 🗆	Tax ID# or social security # of Day Care provider	Day Care provider		
SUMMARY OF EXPENSES				Dates of service **	ce **	
Name of person	Age	Relationship	Provider of services*	From	Ъ	Amount to
receiving services	and grade	to employee	and address	Mo/Day/Yr	Mo/Day/Yr	be reimbursed
 "Provider" means day care center, person who gave care, etc. "Ise date on which service was provided not the date you paid for it. 	on who gave car	e, etc. nu naid for it			TOTAL	

DATE

AUTHORIZATION #

INITIAL

SIGNATURE OF DAY CARE PROVIDER

The above is a true and accurate statement of unreimbursed medical or dependent care expenses provided to me or my eligible dependents on the date(s) indicated. I have read and understand the information on the back of this form. I understand that I am responsible for misrepresentation regarding requests for reimbursement.

The state of the s				
	FOR OFFICE	DATE	AUTHORIZATION #	INITIAL
SIGNATURE: DATE:	USE ONLY			

^{***} If the facility is Tax Exempt, the I.D. Number is not required.